Provider Tips Archives

Contents

All Providers

June 04, 2015: How to use the CHAMPS Claim Limit List

May 04, 2015: CHAMPS Navigation

April 08, 2015: CSHCS Provider Information Page

March 19, 2015: ICD-10 Virtual Presentation

March 10, 2015: How to Adjust a claim with Other Insurance

March 10, 2015: Refund of Payment

March 10, 2015: Benefits Monitoring Program (BMP):

- Benefits Monitoring Program
- Verifying BMP Eligibility
- Beneficiary Notification Letter Example
- Beneficiary Final Notification Letter Example
- MSA 1302 for Specialty Referrals

October 01, 2013: MDCH-ICD10 Virtual Training

March 07, 2013: ICD-10 Virtual Training

December 11, 2012: ICD-10 Presentation

December 3, 2012: Medicare Part D Coverage of Benzodiazepines and Barbiturates 1/1/2013. As of January 1, 2013, Medicare Part D plans will begin covering benzodiazepines and barbiturates (i.e. barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder). For additional information on the Part D coverage changes, please visit the Michigan Medicaid website https://michigan.fhsc.com

October 26, 2011: 5010 Professional DDE

October 26, 2011: 5010 Institutional DDE

October 3, 2011: Local CSHCS Office Contact Info

January 15, 2010: PERM Audit Information

August 27, 2008: CMS 1500 Claim Completion Instructions

June 14, 2005: Listserv Instructions- Updated 09.22.2009

Ambulance

March 24, 2016: Tips for Requesting Prior Authorization

March 24, 2016: Non-emergent Ambulance Services Denials on Medicare Primary Crossover Claims: Providers are encouraged to report the referring physician field when sending claims to Medicare in order to avoid claim denials with CARC 208, N286, and N290 on the crossover claim. Medicaid requires an enrolled ordering/referring/attending physician to be on all non-emergent ambulance services billed. For professional ambulance claims, this is Loop 2310A or 2420F (Referring) or Loop 2420E (Ordering). For institutional claims, this is Loop 2310A (Attending) or Loop 2310F or 2420D (Referring).

Clinics

March 23, 2016: Billing Tips-Vaccine for Children (VFC)

February 24, 2015: Clinic Billing Tips

Dental

January 29, 2016: Claims being submitted for beneficiaries residing in a Nursing Home, a referring NPI is mandatory on the claim. The referring NPI can be obtained from the Nursing Home.

Nursing Facility (SNF)

August 11, 2016: Denials for LOCD Not Complete

November 06, 2015: Level of Care Determination (LOCD) Tool within CHAMPS

July 18, 2011: Hospital Swing Beds are to report Type of Bill (TOB) as 018x.

July 01, 2011 : All Nursing facility providers must report Medicare information if the beneficiary has active Medicare on file, even if Medicare benefit exhausted (billing after 100-day benefit period) or billing for non-skilled level of care.

June 30, 2011: Outpatient County Medical Care Facilities: Report Type of Bill (TOB) as 23X when billing for therapies.

June 23, 2011: Report Covered, Non-Covered and Co-Ins Days based on Primary insurance with Value code 80, 81 and 82.

June 23, 2011: Exhausted Medicare Part A Benefits - Report Occurrence Code A3 and the last date patient had Medicare Part A and report Medicare information with appropriate CARC/Reason Code 119 or 96 and reason why it was not covered by Medicare.

June 23, 2011: Total of units for Room and Board and Leave Days on line level should be equal with number of days reported on FROM and TO Date (UB04 - Form Locator 6).

May 25, 2011: Reporting Leave Days: When billing leave days, FROM/ TO Dates and quantity must be reported on service line.

May 25, 2011: All Nursing facility providers should report Medicare information if the beneficiary has active Medicare on file, even if they are Medicaid only (non Medicare certified bed) facilities.

December 1, 2010: Attention Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Hospice, and Home Health Agencies: The Medical Services Administration has noted that providers are incorrectly reporting OR not reporting other insurance or Medicare on claims to Medicaid. When billing Medicaid if there is a primary insurance the appropriate other insurance information must be reported on the claim. Below are some of the most common ways to report specific situations with other insurance:

1. If Medicare Part A is exhausted report Occurrence Code A3 indicating the last date that benefits are not available.
2. If other insurance does not cover the service, or is no longer available to the beneficiary, or there is an invalid insurance code on the Medicaid Eligibility Card, report Occurrence Code 24 or 25 accordingly.
3. Use proper CAS codes to identify the information from the Medicare EOB or commercial insurance EOB.

To ensure proper adjudication of the claim and unnecessary denials, appropriate information must be reported. This should take place on all subsequent claims as well as the initial claim.

Pharmacy/Durable Medical Equipment (DME)

April 26, 2016: DME Provider Verification Tool

April 20, 2016: Blood Glucose Monitoring Equipment and Supplies

Physician/Professional

August 22, 2016: Provider Verification Tool Guide

August 16, 2016: Professional Updates

February 26, 2016: Billing Tips-Vaccine for Children (VFC)

March 10, 2015: Immunizations Administration and Preventive Medicine Services.

Return to Top